

BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

RONALD L. CHRIST, M.D.

Holder of License No. 6644
For the Practice of Allopathic Medicine
In the State of Arizona

Case No. MD-05-0495A

**CONSENT AGREEMENT FOR
LETTER OF REPRIMAND**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Ronald L. Christ, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter.

2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. The Board may adopt this Consent Agreement of any part thereof. This Consent Agreement, or any part thereof, may be considered in any future disciplinary action against Respondent.

5. This Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any waiver,

1 express or implied, of the Board's statutory authority or jurisdiction regarding any other
2 pending or future investigation, action or proceeding. The acceptance of this Consent
3 Agreement does not preclude any other agency, subdivision or officer of this State from
4 instituting other civil or criminal proceedings with respect to the conduct that is the subject
5 of this Consent Agreement.

6 6. All admissions made by Respondent are solely for final disposition of this
7 matter and any subsequent related administrative proceedings or civil litigation involving
8 the Board and Respondent. Therefore, said admissions by Respondent are not intended
9 or made for any other use, such as in the context of another state or federal government
10 regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or
11 any other state or federal court.

12 7. Upon signing this agreement, and returning this document (or a copy thereof) to
13 the Board's Executive Director, Respondent may not revoke the acceptance of the
14 Consent Agreement. Respondent may not make any modifications to the document. Any
15 modifications to this original document are ineffective and void unless mutually approved
16 by the parties.

17 8. If the Board does not adopt this Consent Agreement, Respondent will not
18 assert as a defense that the Board's consideration of this Consent Agreement constitutes
19 bias, prejudice, prejudgment or other similar defense.

20 9. This Consent Agreement, once approved and signed, is a public record that will
21 be publicly disseminated as a formal action of the Board and will be reported to the
22 National Practitioner Data Bank and to the Arizona Medical Board's website.

23 10. If any part of the Consent Agreement is later declared void or otherwise
24 unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force
25 and effect.

1 11. Any violation of this Consent Agreement constitutes unprofessional conduct
2 and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("violating a formal order,
3 probation, consent agreement or stipulation issued or entered into by the board or its
4 executive director under this chapter") and 32-1451.

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7 
8 RONALD L. CHRIST, M.D.

DATED: 21 Dec '06

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 6644 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-05-0495A after receiving notification of a malpractice settlement involving Respondent's care and treatment of a thirty-six year-old female patient ("PL").

4. PL was referred to Respondent on November 3, 2001 for right-sided abdominal pain. Respondent ordered a computed tomography ("CT") scan and read it as demonstrating cholelithiasis ureteral lithiasis. Respondent treated PL with hydration and the pain temporarily resolved. Between November 2001 and February 2003 PL continued to have episodes of discomfort. On February 4, 2003 PL presented to the emergency room with abdominal pain, nausea and vomiting. Respondent scheduled PL for a laparoscopic cholecystectomy on February 5, 2003. The pathology report from the procedure demonstrated chronic cholecystitis and cholelithiasis. Respondent discharged PL on February 6, 2003 with instructions to return to see him on February 12, 2003.

5. On February 11, 2003 PL developed severe abdominal pain and returned to the emergency room. Respondent performed a physical examination showing PL was afebrile with a pulse rate of 80 with a soft, but tender abdomen. On February 12, 2003 Respondent noted PL's pain persisted and her temperature was 100.3. Respondent ordered an abdominal CT scan that demonstrated "[a] small amount of fluid adjacent to the gallbladder fossa as well as the liver. There [was] also pelvic free fluid." Respondent did not order any further diagnostic testing, such as a diagnostic endoscopic retrograde cholangiopancreatography ("ERCP").

1 6. On February 13, 2003 Respondent took PL to the operating room with a pre-
2 and post-operative diagnosis of bile leak from the common bile duct. The operative report
3 indicated the clip placed on the cystic duct was intact, but there was a "small lateral defect
4 in the common duct through which bile was leaking" less than 1 cm above the cystic duct.
5 Respondent placed a 22 French T-tube into the common duct through the defect and
6 believed he obtained proximal and distal filling after placing some sutures around the T-
7 tube in order to get a better seal. Respondent then placed a Jackson-Pratt drain near the
8 T-tube, brought it outside the abdomen and closed the abdomen. On February 14, 2003
9 Respondent noted significantly more bile was coming out of the Jackson-Pratt drain than
10 the T-tube. Respondent consulted a gastroenterologist who recommended PL be
11 transferred to another hospital for surgery.

12 7. On February 14, 2003 PL was transferred and taken to the operating room
13 by a general surgeon ("General Surgeon") who observed the T-tube appeared to be sitting
14 free in the right upper quadrant and not in the duct. General Surgeon noted the common
15 duct was transected and the distal end of the common bile duct was separated from the
16 proximal bile ducts by over 2 cm. General Surgeon trimmed back coagulation necrosis of
17 the left and right hepatic ducts and performed separate Roux-en-Y hepaticojejunostomies
18 to the left and right hepatic ducts. PL improved and was discharged on February 20, 2003.

19 8. When a patient develops a bile leak following laparoscopic cholecystectomy,
20 the standard of care requires a physician to arrange for the patient to have a diagnostic
21 ERCP.

22 9. Respondent deviated from the standard of care because he did not arrange
23 for PL to have a diagnostic ERCP when he suspected a bile leak following laparoscopic
24 cholecystectomy on February 11, 2003.

1 10. PL underwent an unnecessary surgery. PL was also at risk for an infection
2 and other side effects of unnecessary surgery and anesthesiology.

3 **CONCLUSIONS OF LAW**

4 1. The Board possesses jurisdiction over the subject matter hereof and over
5 Respondent.

6 2. The conduct and circumstances described above constitute unprofessional
7 conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be
8 harmful or dangerous to the health of the patient or the public") and A.R.S. § 32-1401
9 (27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or
10 negligence resulting in harm to or the death of a patient.").

11 **ORDER**

12 IT IS HEREBY ORDERED THAT:

13 1. Respondent is issued a Letter of Reprimand for failure to arrange for a
14 diagnostic endoscopic retrograde cholangiopancreatography.

15 2. This Order is the final disposition of case number MD-05-0495A.

16 DATED AND EFFECTIVE this 9th day of February, 2008.⁷

17
18 (SEAL)



ARIZONA MEDICAL BOARD

By 

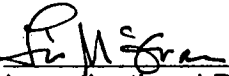
TIMOTHY C. MILLER, J.D.
Executive Director

1 ORIGINAL of the foregoing filed
2 this 9th day of February, 2006 with:

3 Arizona Medical Board
4 9545 E. Doubletree Ranch Road
5 Scottsdale, AZ 85258

6 EXECUTED COPY of the foregoing mailed
7 this 9th day of February, 2006 to:

8 Ronald L. Christ, M.D.
9 Address of Record

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11 _____
12 Investigational Review
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